

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____

Daytime phone number or number where you can be reached (_____) _____

(Complete if you would like your records released from Dakota Radiology to any individual or entity.)

1. REQUEST RECORDS FROM Dakota Radiology, 2929 5th Street, Suite 100, Rapid City, SD 57701

TO (NAME): _____

ADDRESS: _____

(Complete if you have prior exams//films/records that you need to be release to Dakota Radiology.)

2. RELEASE RECORDS TO Dakota Radiology, 2929 5th Street, Suite 100, Rapid City, SD 57701

FROM: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE# _____ FAX# _____

3. PURPOSE

- At the request of the patient
- Continued Care
- Other _____

Covering the dates of service FROM _____ TO _____

4. I would like the following information released:

5. Without my express revocation, this authorization will expire in 180 days from date of signature. A copy or fax of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing. A copy of this signed authorization will be provided to the patient.

- A. Authorization, I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting my request in writing, except to the extent that action has already been taken to comply with it.
- B. I understand that I do not have to sign this authorization. I understand that my treatment or payment for services will not be denied if I do not sign this form.
- C. Re-disclosure, I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

6. SIGNATURE Patient _____ Date _____

7. If other than the patient, indicate relationship _____ Parent _____ Guardian/Legal representative/POA (circle one)

Identity of Patient and/or Signature verified via _____ Photo ID _____ Matching Signature _____ Other _____